Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-282
Employees' Manual, Title 8
Medicaid Appendix

December 14, 2007

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 07-3

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Prescribed Drugs***, Chapter III, *Provider-Specific Policies*, the following forms:

470-4116	*Request for Prior Authorization: ADD/ADHD/Narcolepsy Agents*, revised
470-4095	*Request for Prior Authorization: Antihistamines*, revised
470-4117	*Request for Prior Authorization: Benzodiazepines*, revised
470-4104	*Request for Prior Authorization: Miscellaneous*, revised
470-4105	*Request for Prior Authorization: Muscle Relaxants*, revised
470-4108	*Request for Prior Authorization: Non-Preferred Drug*, revised
470-4109	*Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, revised
470-4327	*Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, revised
470-4114	*Request for Prior Authorization: Tretinoin – Topical*, revised
470-4115	*Request for Prior Authorization: Vitamins & Minerals*, revised

Summary

Revisions to the manual include current forms for requesting drug prior authorization.

Date Effective

January 1, 2008

Material Superseded

Remove the following forms from Chapter III of the ***Prescribed Drugs Manual*** and destroy them:

Page	Date
470-4116	5/07
470-4095	5/07
470-4117	1/05
470-4104	1/05
470-4105	10/07
470-4108	1/05

470-4109	5/07
470-4327	10/07
470-4114	1/05
470-4115	1/05

For those filing paper manuals, form samples should be removed from Chapter III of the ***Prescribed Drugs Manual*** and destroyed. *Request for Prior Authorization* samples should be filed in alphabetical order by title following page 40.

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
ADD/ADHD/NARCOLEPSY AGENTS
This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior Authorization is required for ADD/ADHD/Narcolepsy Agents for members 21 years of age or older.

Preferred				**Non-Preferred**			
Amphetamine Salt Combo	☐	Methylin ER	☐	Adderall	☐	Metadate ER	☐
Dexedrine Caps	☐	Methylphenidate	☐	Desoxyn	☐	Ritalin	☐
Dextroamphetamine 10mg	☐	Methylphenidate ER	☐	Dextroamphetamine 5mg	☐	Ritalin SR	☐
Dextrostat 5mg	☐	Methylphenidate SR	☐	Dextrostat 10mg	☐		
Methylin	☐						

Recommended				**Non-Recommended**			
Adderall XR	☐	Focalin	☐	Metadate CD	☐	Ritalin LA	☐
Concerta	☐	Focalin XR	☐	Provigil	☐	Strattera	☐
Daytrana Patch	☐	Vyvanse	☐				

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:

☐ **Attention Deficit Disorder (ADD)** ☐ **Attention Deficit Hyperactivity Disorder (ADHD)**

☐ **Narcolepsy** ☐ **Other (specify)**_____**(see below)***

☐ **Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)**

Have non-pharmacological treatments been tried? ❑ No ❑ Yes *If Yes, please indicate below:*

☐ **Weight Loss** ☐ **Position therapy**

☐ **CPAP Date: _____ Maximum titration? ❑ Yes ❑ No**

☐ **BiPAP Date: _____ Maximum titration? ❑ Yes ❑ No**

☐ **Surgery Date: _____ Specifics:**_____

Date of Diagnosis:_____ Test used for diagnosis:_____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons:_____

***Other** - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges: _____

_____

Reason for use of Non-Preferred drug requiring approval:_____

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
ANTIHISTAMINES
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for all non-preferred antihistamines and preferred 2nd generation legend antihistamines.
Patients 21 years of age and older must have two unsuccessful trials with an antihistamine that does not require prior authorization, prior to the approval of a non-preferred 1st generation or preferred 2nd generation legend antihistamine. One of the trials must be loratadine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation legend antihistamine.
Patients 20 years of age and younger must have an unsuccessful trial of loratadine prior to the approval of a non-preferred 1st generation or preferred 2nd generation legend antihistamine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation legend antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred 1st Generation Antihistamines (no PA required)
Chlorpheniramine Maleate (OTC)
Cyproheptadine
Diphenhydramine (OTC)
Other preferred as listed on PDL

Preferred 2nd Generation OTC Antihistamines (no PA required)
Alavert (OTC)
Loratadine/Loratadine Syrup (OTC)
Tavist ND (OTC)

Preferred 2nd Generation, Legend Antihistamines (PA required)
Clarinex ☐
Clarinex D ☐
Clarinex Reditabs ☐
Zyrtec ☐
Zyrtec D ☐
Zyrtec Syrup ☐
Zyrtec Chewable ☐

Non- Preferred 1st Generation Antihistamines (PA required)
Astelin ☐
Clemastine Fumarate ☐
Dexchlorpheniramine Maleate ☐
Dexchlor Repeat Action ☐
Palgic ☐
Rondec ☐
Other **(specify)** _____ ☐

Non-Preferred 2nd Generation Antihistamines (PA required)
Allegra ☐
Fexofenadine ☐
Xyzal ☐
Allegra D ☐
Fexofenadine/PSE ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Document antihistamine treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
BENZODIAZEPINES

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___||

Prior authorization is required for non-preferred benzodiazepines. Requests must document a previous trial and therapy failure with two preferred products. Prior authorization will be approved for up to 12 months for certain documented diagnoses and a 3 month period for all other diagnoses. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine.

Preferred

Alprazolam	Estazolam
Chlordiazepoxide	Flurazepam
Clonazepam	Lorazepam
Clorazepate 7.5mg	Oxazepam
Clorazepate 15mg	Temazepam
Diazepam	Tranxene 3.75mg
Estazolam	Triazolam

Non-Preferred

Ativan ☐	Klonopin ☐	
Alprazolam ER ☐	Klonopin Wafers ☐	Restoril 30mg ☐
Clorazepate 3.75mg ☐	Librium ☐	Serax ☐
Dalmane ☐	Prosom ☐	Xanax ☐
Halcion ☐	Restoril 15mg ☐	Xanax XR ☐

Other **(specify)**_____ ☐

Recommended

Diazepam Concentrate	Doral
Diazepam Solution	Restoril 7.5mg

Non-Recommended

Tranxene SD ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:

- ❑ **Generalized anxiety disorder**
- ❑ **Panic attack with or without agoraphobia**
- ❑ **Seizure**
- ❑ **Other (please specify)** _____
- ❑ **Non-progressive motor disorder**
- ❑ **Dystonia**

Trial 1 with preferred agent: Drug Name_____ Strength_____

Dosage instructions_____ Trial Date from_____ Trial Date to_____

Trial 2 with preferred agent: Drug Name_____ Strength_____

Dosage instructions_____ Trial Date from_____ Trial Date to_____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
MISCELLANEOUS
ONE Drug per Form ONLY
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Drug Name:_____ Strength:_____

Dosage Instructions:_____ Quantity:_____ Days Supply: _____
(31 DAYS MAX)

Length of Therapy on Prescription (Date Range):_____

Diagnosis:_____

Previous therapy (include drug name(s), strength and exact date ranges): _____

_____

_____

Pertinent Lab Data:_____

Other medical conditions to consider: _____

_____

Possible drug interactions/conflicting drug therapies:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
MUSCLE RELAXANTS

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___||

Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants.

Preferred

Baclofen
Chlorzoxazone
Cyclobenzaprine
Lioresal Intrathecal
Methocarbamol
Orphenadrine ER/CR
Orphendrine/ASA/Caffeine 25/385/30
Tizanidine 4mg

Non-Preferred

Amrix ☐
Carisoprodol ☐
Carisoprodol/ASA ☐
Carisoprodol/ASA/Codeine ☐
Dantrium ☐
Flexeril ☐
Orphenadrine Compound DS ☐
Norflex ☐
Orphengesic Forte ☐
Skelaxin ☐
Soma ☐
Tizanidine 2mg ☐
Zanaflex ☐
Other **(specify)**_____ ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Preferred Trial 1: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 2: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 3: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
NON-PREFERRED DRUG
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

***If requesting a non-preferred brand-name product, failure on generic equivalent is required.**
Please use the Selected Brand Name Drugs prior authorization form.

Drug Name:_____ Strength:_____

Dosage Instructions:_____ Quantity:_____ Days Supply: _____

Diagnosis:_____

Previous therapy (include drug name(s), strength and exact date ranges):_____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

Pertinent Lab data:_____

Other medical conditions to consider:_____

_____

Other relevant information:_____

Possible drug interactions/conflicting drug therapies:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all preferred single source COX-2 inhibitors. Requests must document previous trials and therapy failure with at least two multi-source preferred nonsteroidal anti-inflammatory drugs. In addition to these two required trials, requests for a non-preferred COX-2 inhibitor must also include documentation of a previous trial and therapy failure with a preferred COX-2 inhibitor. Prior authorization is not required for prescriptions for preferred multi-source nonsteroidal anti-inflammatory drugs.

Preferred (PA required only for bolded products)

Diclofenac Sod.
Diclofenac Sod. EC/DR
Etodolac 400mg/500mg
Fenoprofen
Flurbiprofen
Ibuprofen
Ibuprofen Susp.
Indomethacin
Ketoprofen
Ketoprofen ER
Meloxicam (COX-2)
Nabumetone (COX-2)
Naprosyn Susp.
Naproxen
Naproxen EC/ER
Naproxen Sodium 550mg
Oxaprozin
Piroxicam
Sulindac

Non-Preferred (PA required for all products)

Arthrotec 50 ☐
Arthrotec 75 ☐
Cataflam ☐
Celebrex ☐
Clinoril ☐
Daypro ☐
Diclofenac Pot. ☐
Diclofenac Sod. ER/XR ☐
EC-Naprosyn ☐
Etodolac CR/ER/XR ☐
Indomethacin ER ☐
Meclofenamate Sod ☐
Mobic ☐
Motrin ☐
Naprelan ☐
Naprosyn ☐
Oruvail ☐
Ponstel ☐
Relafen ☐
Tolmetin Sodium ☐
Voltaren ☐
Voltaren XR ☐
Other (specify) _____ ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Trial 1 multi-source preferred product: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from:_____ Trial date to:_____

Trial 2 multi-source preferred product: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from:_____ Trial date to:_____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other relevant information:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
PULMONARY ARTERIAL HYPERTENSION AGENTS
This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for agents used to treat pulmonary hypertension.

Preferred		**Non-Preferred**	
Flolan	☐	Letairis	☐
Revatio	☐		
Tracleer	☐		
Ventavis	☐		

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:

- ❑ **Pulmonary arterial hypertension**
- ❑ **Other (please specify)_____**

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

_____

Other medical conditions to consider:_____

_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
TRETINOIN - TOPICAL

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for all tretinoin prescription products. Payment for non-preferred tretinoin products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Alternatives such as topical benzoyl peroxide (OTC), and topical or oral antibiotics must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne. Trials and therapy failure will not be required for those members presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of tretinoin products. Requests for the combination products will only be considered after the member has documented unsuccessful separate trials with tretinoin and topical benzoyl peroxide (OTC), and topical or oral antibiotics.

Preferred		**Non-Preferred**			
Tretinoin	☐	Retin-A	☐	Ziana	☐
		Retin-A Micro	☐		

Strength	**Form (cream, gel, etc.)**	**Usage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____	_____

Diagnosis: **Date of Diagnosis:_____**

- ❑ **Acne Vulgaris***
- ❑ **Cystic Acne**
- ❑ **Preponderance of Comedonal Acne**
- ❑ **Skin Cancer**
- ❑ **Other (please specify): _____**

*If **Acne Vulgaris**, please **document oral or topical antibiotic and benzoyl peroxide trial(s)**, including drug name(s), strength, dose and exact date range:_____

_____

Medical or contraindication reason to override trial requirements: _____
Reason for use of Non-Preferred drug requiring prior approval:_____
Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
VITAMINS & MINERALS

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NABP or

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for recipients aged 20 or under if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for a legend product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)

Drug Name:_____ Strength:_____

Dosage Instructions:_____ Quantity:_____ Days Supply: _____

Diagnosis:_____

Other medical conditions to consider:_____

_____

Attach lab results and other documentation as necessary (Required).

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.